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ABSTRACT

Three regional workshops held by the Alabama Center for Higher Education to sensitize minority professionals to the severely involved population and to encourage participation of minority professionals in the developmental disabilities service system are described. Background information on P.L. 94-142, the Education for All Handicapped Children Act, is presented, and implications for blacks and traditionally black institutions of higher education are considered. A core curriculum in developmental disabilities based on knowledge of normal growth and development and on the importance of interdisciplinary teamwork is described. Aberrations in normal development as represented by mental retardation, cerebral palsy, epilepsy, autism, blindness, and auditory disability are discussed. Five courses are outlined which provide basic growth and development information along with field experience. (CL)

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"AN INTERDISCIPLINARY CURRICULUM TO MEET THE NEEDS OF DEVELOPMENTALLY DISABLED CHILDREN"

This paper is an outgrowth of a grant received by the Alabama Center for Higher Education (ACHE), whose membership includes, the seven, four year colleges, historically Black colleges and universities in the state of Alabama. Although, the grant was given in the state of Alabama, it was national in scope. It had two primary objectives, one; to implement strategies for the purpose of increasing the number and quality of minority professionals in the developmental disabilities service system and two; develop a model for increased and improved relationships with the developmental disabilities service system which may be replicated by historically Black colleges and universities both individually and collectively.

In carrying out the objectives of the proposal, three regional workshops were convened at residential facilities for the developmentally disabled for faculty from historically Black institutions of higher education across the country who represent disciplines that have knowledge/skills basic to solving problems unique to persons with developmental disabilities. The workshops were held at Brewer Developmental Center, Mobile, Alabama; Austin State School, Austin, Texas; Southside Virginia Training Center, Petersburg, Virginia. The primary purpose of the facilities was to sensitize the professionals to population of severely involved consumers. Secondly, to interface with other professionals who are involved in this population on a forty (40) hour basis. As a result of these workshops, the Alabama Consortium for Higher Education has assumed both a leadership

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and catalytic role in bridging the gap between historically Black colleges and universities and the developmental disabilities system, by developing a framework for a national model or collaboration.

Each of the workshop sites had a disproportionate number of Black developmentally disabled residence/consumers, but a paucity of Black professionals on their staffs.

There are a series of assumptions based on objective observations about the developmentally disabled; however, there has been little done programmatically to deal with these assumptions.

Assumptions:

1. The problems of a developmentally disabled child is so complex, that family members and special educators have been restricted in their efforts to provide comprehensive educational programs.

2. The special educator finds himself/herself working in a collaborative effort with other professions.

3. As deinstitutionalization becomes more widespread, more profoundly developmentally disabled children, in particular, the Black child, will be found in the local school system.

4. In order to develop a greater sense of awareness and empathy, more special education teacher education programs, should include field base courses.

5. Developmental disabilities is an expanding area, mandated by federal and state governments for implementation. It can be safely assumed that the demand for well trained professionals will continue unabated for years to come.

6. Developmental disabilities requires a collaborative effort between and among several disciplines to be effective. Without exception, Black institutions of higher education have not or are not utilizing this approach in their curriculae.

7. There is a common concern expressed by officials

and administrators of special education, that students are presently not well trained to deal effectively with this population.

8. The number of severely involved developmentally disabled children who are Black is extremely high, particularly for those requiring intervention techniques in special education.

It is most appropriate at this point in time, to define just what we mean by a developmental disability. Actually, it is a legal term based on the principles outlined by our founding fathers.

Federal Legislation

The Fourteenth Amendment to the United States Constitution guarantees equal protection under the law for all citizens. Yet, it has required a long series of court cases and federal regulation to make "equal protection," with respect to education, a reality for the eight million developmentally disabled. Utilizing many aspects of the civil rights movement of the 1950's and 1960's, legislation guaranteeing basic civil rights for the developmentally disabled is guaranteed in the light of a series of landmark cases.

Legal Definition

The term "developmental disabilities," coined with the passage of the Developmental Disabilities Services and Facilities Construction Act of 1970 (Public Law 91-517), amended by the Developmentally Disabled Assistance and Bill of Rights Act (Public Law 94-103) and again amended by the Rehabilitation Act Amendments of 1978 (Public Law 95-602), refers to a disability attributable to mental retardation, cerebral palsy, epilepsy, or other neurologically handicapped

condition of an individual found to be closely related to mental retardation or to require treatment similar to that required by mentally retarded individuals, and

1. the disability originates before such individual attains age 22,
2. and has continued, or can be expected to continue indefinitely,
3. and constitutes a substantial handicap of such individuals.

Functionally, it is a break from the former categorical definition that labeled children as mentally retarded, cerebral palsy, deaf, blind, etc. It is basically an abberation of the normal growth and development that most children experience. It is developmental in nature and may include all of, or some of the following deficits: intellectual, motor, perceptual, emotional, and physical. It is therefore critical for the special educator to understand that these deficits are not mutually exclusive but are highly interrelated. The challenge for the special educator is to recognize that all of these aforementioned deficits have their greatest growth prior to the child entering school. The time has not arrived yet, nor is it economically affordable at present to offer formal education starting at the third month of life. We are referring to normal maturation that takes place for most children.

It has not been too many years ago, when the school system had a pat answer to the question of the developmentally disabled child, exclude them. In the final analysis, it is better for society, the child, and the parents to place these children in institutions. There, they will be happy with each other; their daily needs will be

taken care of, and they will be less of a burden to all of us. Unfortunately, it does not work that way, institutions are dehumanizing, expensive, and a waste of human potential. Summarily, it is illegal, the developmentally disabled have basic human rights, and they have potential for growth in all areas. The one professional who will contribute the most, who will have the greatest mandate, who will put in the most man hours, and have the greatest impact is the special educator.

As a result of recent legislation from the level of the supreme court with regard to equal protection under the law are the basic rights for all citizens, the major agency for intervention is now the educational system. Every state must educate ALL children. All states have not responded as they should; many claim they lack the resources and the skilled personnel to implement court mandates. The greatest advance the educational system offers is that through education one is gearing towards entering society as a competitive individual. The chief complaint relative to the school system is that the system has no control until five or six years. Education is seldom mandated prior to the fifth or sixth year of age. It is crucial that instruction began before this age for developmentally disabled children. The Head Start Program is mandated to have 10% handicapped children. However, this has been interpreted in a wide variety of ways.

School programming for the developmentally disabled child varies widely from state to state, depending upon community attitudes, resources -- both professional and financial -- and the intensity of the advocates. There are usually special schools for developmentally disabled children -- particularly for the blind and deaf. Many schools

will have special classes for the developmentally disabled child in a school building for so-called normal children. Despite many court edicts, these schools are segregated. Many parents prefer segregation because they feel their children require special personnel, staff, and approaches. The newest trend is called mainstreaming. This implies that a developmentally disabled child should be educated along with his so-called normal peer for all the reasons that support growth of the whole child. Can a severely involved cerebral palsied or mentally retarded child profit by being in a class with his so-called normal peers? This is a most difficult question; but most educators agree that all children can have some level of mainstreaming. It is not necessary that they be in class all day together, but possibly be in a common home room, an assembly, a leisure hour. Thus, a child should be mainstreamed as much as his condition will permit and mitigate, to enhance his education and growth.

With respect to education, the most important conceptual basis which is supported in law by P.L. 94-142, "The Education for All Handicapped Children Act," is the IEP (individual education plan). This law requires each state and local educational agency to develop individualized education plans for each child receiving special education. The law has four major purposes:

1. To guarantee the availability of special education programming to handicapped children and youth who require it.

2. To assure fairness and appropriateness in decision-making about providing special education to all levels of government.

3. To establish clear management and auditing requirements and procedures regarding special education at

levels of government.

4. To financially assist the efforts of state and local governments through the use of federal funds.

The IEP is further supported by the related services clause, which defines related services as transportation, and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a handicapped child to benefit from special education, and includes the early identification and assessment of handicapping conditions in children.

The key phrase here is "as required to assist the handicapped child to benefit from special education." This leads to a clear progression: a child is handicapped because he or she requires special education and related services; special education is the specially designed instruction to meet the child's unique needs; and related services are those additional services necessary in order for the child to benefit from special educational instruction.

No one doubts that the problem of the developmentally is a national problem of tremendous scope and is a challenge for our entire educational system. For Blacks, however, the challenge is even greater. There is now, a continuing paucity of Black professionals in the devemental disabilities system. Whereby Blacks are highly represented in positions requiring on-the-job training (i.e., aids, technicians, and support personnel) professionals in the direct service, middle management and top management are less than three percent.

It is most appropriate that Black institutions of higher education address this problem as a priority. History has demonstrated that Black institutions are the major producers of Black professionals. Institutions are change agents; therefore this role is in keeping with our history and tradition.

The major reason for Blacks and Black institutions to become actively involved in developmentally disabled is that the consumers in the system show a disproportionate number of Blacks. This is particularly true of the educable mentally retarded. There are many factors that are active here, that I need not mention; however, the facts speak for themselves.

The question now arises, what is the best method, and how do we produce special educators at historical Black institutions to respond to this challenge. After much discussion and research the Alabama Center for Higher Education chose the mini-team concept as a model.

The problem of persons with a developmental disability may be so complex that family members and helping professionals have been restricted in their efforts to provide comprehensive programs, services, and developmental care. In the late 1960's, representatives from the National Association for Retarded Citizens, United Cerebral Palsy Associations, Inc., the University of Indiana, University of Wisconsin and Central Wisconsin Colony and Training School met to pool their knowledge relative to the care, treatment and program planning requirements for persons with severe profound, multiple disabling conditions. Out of this series of meetings, the concept of "cross disciplinary" and "cross modality" training of professionals evolved. As the result, small teams of persons from six institutions were

trained in new approaches to therapeutic care of institutions residents. The "mini-team" was born.

In the mid 1970's, the mini-team concept was broadened to include a number of professional disciplines. Whereas the original mini-teams included only the professions of Nursing, Physical Therapy, Occupational Therapy -- the new mini-teams developed included combinations of professionals from other disciplines such as Speech Pathology, Therapeutic Recreation, Special Education, Social Work, and Nutrition. United Cerebral Palsy of New York State initiated the use of the mini-team for training of direct-care personnel in a state institution by consultant mini-teams from the private sector.

The original mini-teams were selected and trained to work with residents of state and private institutions for persons with mental retardation and other developmental disabilities. Over the time, role and scope of new mini-teams has broadened to include community based programs.

The mini-team consists of persons willing and able to work with others in the development of jointly planned programs for one or more persons with developmental disabilities. These team members assume responsibility for providing cooperative and coordinated services/treatment using knowledge/skill from the participating professional disciplines. Problem solving and intervention are based upon interdisciplinary efforts of the team. With the most sophisticated teams, a transdisciplinary approach has evolved -- whereby team members are committed to teaching/learning/working together with others across traditional disciplinary boundaries.

The transdisciplinary approach is the deliberate pooling/exchange

of knowledge and skills which result in continuous crossing of traditional disciplinary boundaries within the limits of licensure by team members. Thus, the teaching/learning activities of the team are focused around the needs and problems of persons with developmental disabilities. Once trained to operate in the transdisciplinary approach, any one team member can work as the primary case coordinator in the habilitation process for the client with developmental disabilities. This includes training others in therapeutic management and developmental programming. Other team members are utilized as consultants in the case management developmental program.

The success of the interdisciplinary team as teacher, consultant, program service provider is well documented in terms of cost effectiveness and impact on the development of persons with severe/profound limitations. This is the care for both residential/institutional based programs and community services.

Several processes have been constant in the development of the mini-team as trainers and as service providers:

1. The team members learn from each other in an environment where persons with developmental disabilities receive services.

2. Team members teach others in an environment where the person with a developmental disability is provided services.

3. Team members teach in an interaction process with other team members, the trainees, the persons with the developmental disability and his/her family.

4. Team members are competent as generalists in the knowledge/skill of their own discipline prior to becoming a team member who is able to cross disciplinary lines.

The mini-team is capable of covering curriculum content in a

number of areas that have great impact in the provision of services for persons with developmental disabilities:

1. Intervention strategies and techniques that promote growth and development when debilitating conditions are minimized.

2. Promotion of independent function in mobility, communication, self-maintenance, productivity and enrichment and leisure time pursuit.

3. Utilization of community resources in an advocacy approach relative to rights and entitlements of each person with a developmental disability.

Mini-team members are selected from those professional disciplines that have knowledge/skill basic to solving problems that are innate/unique for persons with developmental disabilities. Areas of expertise include neuromotor facilitation, sensory integration facilitation, skills development in mobility, communication and self-maintenance, role behavior development, cognitive development, and utilization of community resources.

The mini-team is in essence a variety of educational and health disciplines, working in a coordinated way to maximize the effect on the developmentally disabled. This team concept in its broadest application. In many instances, the parents are members of the team as well as the disabled individual his/her self. The mini-team concept has as its basis, "No one individual discipline of technique can possibly meet the need demands of the developmentally disabled."

Alabama State University and an active member of the Alabama Consortium has accepted the challenge of initiating a program in the developmentally disabled that is based upon these following critical issues.

1. There is a paucity of Black professionals employed presently in the developmental disabilities service delivery system.

2. Developmental disabilities is an expanding area, mandated by federal and state governments for implementation. It can be assumed that the demand for well trained professionals will continue.

3. While several Black institutions reported curriculae in the developmental disabilities area, they tended to be classic in nature rather than meeting the contemporary needs of the field.

4. Developmental disabilities require a collaborative effort between and among disciplines to be effective. Without exception, Black institutions of higher education have not and are not utilizing this approach in their curriculae.

5. There is a common concern expressed by officials of the Department of Mental Health that students being prepared in disciplines that serve the developmental disability population are not being properly trained to meet the needs of the developmental disabilities.

6. There is a demonstrated need to develop more practicums/and or internships with specific behavioral objectives. With this as a base, studies will be more sensitized to the needs of the developmental disability population.

7. The number of the developmental disability population who are minorities is extremely high, particularly for those requiring intervention techniques in special education. Black institutions of higher education have both an opportunity and a challenge to respond to this human need.

It was our feeling that developmental disabilities require expertise above and beyond which is normally required of a special educator, social worker, or a psychologist. That we do not intend to alter the present method of education, that we basically supplement what we have. Most importantly, professionals in the developmental disabilities system must work as a team. If they are to work as a team, they must be

educated as a team. Thus, we utilized the mainstream as a basic model. A major emphasis must be on field based courses. We therefore have developed an interdisciplinary core curriculum.

CORE CURRICULUM IN DEVELOPMENTAL DISABILITIES

OBJECTIVE: A certificate of proficiency in the developmental disabilities is designed as a supplement to the baccalaureate degree programs in social work, special education, early childhood education, psychology, physical and therapeutic recreation. It is designed to provide a student with skills to work effectively with the developmentally disabled. It is interdisciplinary in its approach to afford the student opportunities and expertise in a coordinated way with several health disciplines to maximize the effect on the developmentally disabled. A major emphasis is the field based practicums, which will develop a sensitivity and an empathy for the target population. Completion of the core curriculum will enhance job opportunities in the developmentally disabled service delivery system and/or better prepare students for graduate studies in human service.

The most salient part of this curriculum is an understanding of normal growth and development, and growth, and development of the

developmentally disabled. One must be fully aware of just where a developmentally disabled child is and basically the nature of what he is.

Normal Growth and Development

The conceptual basis of growth is that it is initially determined by maturation, a genetically determined biological plan of development; one relatively independent of experience. Physical growth and motor development are the two most readily observed signs of growth. They have a common base, being nature rather than natured. Initial physical growth is incredibly rapid immediately following conception and decelerates very quickly thereafter. Since children the world over appear to grow and develop motor skills at pretty much the same rate, regardless of their experience, maturation is assumed to play the major role.

With respect to neural, sensory and perceptual development, the newborn's nervous system is relatively immature. The integration and development of neural, sensory and perceptual systems is directly related to myelinization (the process by which a white, fatty substance grows around the neural axons in the body and acts as an insulator).

The most obvious sign of growth is the achievement of general body control that leads to upright walking, which latter skills use the entire body. Independent walking, as does each stage of motor development throughout the growing period, appears at a comparatively wide range of ages and illustrates nicely arguments against a too rigid adherence to standards of measurement. The average age of independent walking, determined by studies of many children, is somewhere between thirteen and fourteen months. Some children walk as early as nine or

as late as eighteen months. Fast growers walk later. Yet, both are probably developing at a normal rate -- that is, a rate desirable for that individual child which is compatible with his total development.

Acquisition of walking skill, like the achievement of gross motor and fine motor skill, depends upon a number of factors. Basic to all motor growth is that the basic neurological and muscular systems are anatomically and physiologically sound. In addition, plenty of space for general locomotion is needed, along with the opportunity to use the space freely. Normal development of the neuromuscular system is correlated with intellectual growth, but not directly related to it. Delayed walking or fine motor development does not imply retarded mental maturation. There are many reasons why a child might have a lag in his neuromuscular maturation.

The development of the sensory system, or the receptor system -- sight, auditory, taste, smell, and touch -- are well developed at birth. The inputs from the senses and how the brain interprets them is called perception. Perception is, in most instances, directly related to the infant's rate of maturation. Infants are biologically organized to learn many perceptions, such as size, space, etc.

The integration of the sensory system and its coordination with the neuromuscular system is one of the most sophisticated functions of human development. The development of skilled activities, such as future athletic skills and other coordinated functions, is a manifestation of the coordination of the neuromuscular system and perceptual integration.

Conditional growth of infants, despite voluminous research in ethnological, maturational, and social learning, remains unresolved.

Emotional maturity makes us humans. Infants very early develop emotional behavior, such as smiling, laughing, loving, attachments, and fear. Fear of strangers is widespread and develops at about six to eight months of age. No one is sure why this phenomenon takes place. Emotional growth is believed to be directly related to maternal and paternal modeling and activities, and the manifesting of these attitudes in behavior. The proper and appropriate response to stimulus are the signs of emotional growth.

The exact nature of learning is at this point in time still very much based on theory. Learning may be defined as a relatively permanent change in behavior, brought about by practice or experience. The simplest form of learning is habituation, in which an unconditioned response no longer occurs because of repeated presentation of an unconditioned stimulus. Other theories of learning are: the classical conditioning of Pavloving theory; instrumental learning exposed by Thorndike in his laws of effects, reinforcement behavior or modification learning, conceptual learning, as exposed by Piaget. Infants progress at a variety of rates, in terms of learning, but generally, there is a progression which is directly related to the chronological age. When a wide variance exists between chronological age and learning, the child who is blind is said to be retarded. The other extreme is gifted. A child's capacity to learn is still difficult to determine in view of the fact that the process is still based on theory.

Humans are distinguished by their interaction between environment and thought or social learning. Human beings think; and social learning includes complex internal "self-programming" within its scope, because each environmental experience can be altered by thought in a way that

can affect how the experience will be perceived. The internal rules and beliefs that you hold as a result of experience and thinking can further modify the effect of future experience.

Abnormal Growth and Developmental Disabilities

Abnormality in development is an abberation of the normal growth and development as outlined in the preceding pages. A developmental disability may generally be caused by biological damage, missed critical periods of a culture that fails to provide needed experience, or deprivation. Considering the conditions which are included under the definition of developmental disabilities, we will deal with each separately.

Mental Retardation

Mental retardation is the most handicapping of all childhood disabilities. Approximately five (5) million individuals now live in the United States; some 126,000 are born yearly. A much larger number probably function inefficiently throughout life, though never identified. The American Association of Mental Deficiency defines mental retardation as follows: "Mental retardation refers to significantly sub-average intellectual functioning which manifests itself during the developmental period and is characterized by inadequacy in adaptive behavior."

Individuals with mental retardation do not fall easily into any classification. They vary widely in the degree of intellectual deficit and social stability. Some have associated physical handicaps and emotional problems; some do not. Some require protective care; others achieve a striking degree of independence. Some remain

identified as retarded; others slip back into the general population without occasioning any further concern.

In terms of intellectual potential, we use the intelligence quotient range with 90 to 110 as the range of general intelligence. The mildly retarded individual has an intelligence quotient of 50-70; the moderately retarded, 35-50; the severely retarded, 20-35; and the profoundly retarded, below 30. In terms of functional capacity, the manifestations vary with age. Below school age, it is a lag in self-help, locomotive, eating and communication skills; in school, disability in learning; and at the adult level, inability to remain independent or to meet employment requirements.

The mentally retarded are usually divided into three (3) classifications, with reference to education and therapy: (1) The educable are those mildly retarded individuals who can profit from education, and will learn to read and write to about the fourth-grade level. (2) The trainable are those individuals who can learn ADL skills, such as dressing, eating, and bathroom skills. (3) The profound are those individuals who must live in a protective environment and will require complete care. The mode of identification of mental retardation follows a general pattern. The moderately and severely involved, or profoundly handicapped, represent 10-25% of the mentally retarded population, are most apt to be seen in the physician's office or the neonatal clinic. Such diagnoses as mongolism, cranial anomalies, genetic defects, and tumors can be made at that time. Some common findings are malformations, physical handicaps of ambulation, arm and hand use, and sensory impairment.

The largest number of mentally retarded (75-90%) finds the degree

of mental retardation as mild. The IQ is usually above 50. These children are usually identified in school. Those children appear normal; and physical handicaps and congenital malformations are uncommon. After testing, these children are usually placed in special classes. Few of these children are institutionalized and most remain in the community and join the unskilled labor force.

Cerebral Palsy

Cerebral Palsy is a syndrome and not a disease. It is a collection of behaviors and includes disorders of the nervous system, characterized by paralytic symptoms in infancy or childhood. The damage to the nervous system occurs in utero, at birth, or in early post-natal life, and is caused by developmental defects, trauma of labor, post-natal anoxia, interuterine meningitis, or encephalitis, and cerebral vascular accidents of infancy.

Cerebral Palsy was first described by Dr. William John Little in 1863. The condition, for a long time, was called Little's disease. The neural damage can be very limited or quite extensive. Some related disabilities consistent with the extensive nature would be: speech and learning difficulties, mental retardation, physical deformity, and personal problems resulting from failure to experience normal social contacts.

It was formerly thought that there were five (5) distinct forms of cerebral palsy: spastic, athetoid, ataxic, tremor, rigidity. It is now commonly accepted that there are only two types: spastic and athetoid.

Spasticity is characterized by persistent and increased muscle

tone. The muscles involved are contracted and extremely hypertonic. Stiffness is the most significant clinical feature. Voluntary movement is limited.

Athetosis is marked by constantly recurring involuntary movements of an irregular and purposeless pattern. Because of the number and strength of involuntary movements, the athetoid finds it difficult to perform voluntary movements. When there is considerable movement, control of the hands, speech and swallowing is difficult.

It is estimated that there are about seven (7) cerebral palsy births per every 100,000 births. It is conservatively estimated that there are more than 500,000 cerebral palsied individuals of all age groups in the United States.

Epilepsy

Epilepsy is a disease of the central nervous system. It is a sign of the disturbance in the electrochemical activity of the brain. It manifests itself by a temporary loss of consciousness without apparent cause. The unconsciousness may occur with or without convulsions. The transient loss of consciousness without convulsive seizures is known as minor epilepsy (petit mal). The loss of consciousness with convulsive seizures is known as major epilepsy (grand mal). Localized convulsions occurring usually with loss of consciousness are known as Jacksonian or cortical epilepsy.

The name Epilepsy comes from the Greek and means seizure. Seizures and convulsions are descriptive terms used interchangeably. Epilepsy has been classified on the basis of the known and unknown causes of seizures. When the reason is unknown, the condition is

termed idiopathic or asymptomatic; when the cause of the seizure is known, it is termed organic or symptomatic. The idiopathic group includes all those cases in which no structural damage to the nervous system can be shown. Complete understanding of the course of epilepsy is unknown. Complete understanding of the course of epilepsy is unknown. It is believed that the cause of the disarrangement of brain cell activity is due to a combination of factors related to heredity and environment. An inherent predisposition may be touched off by certain abnormalities, such as pressure on the brain from growths or scars, infection, low sugar content of blood. A stabilizing process keeps the brain activity under control in most people. In those with a predisposition to seizures; however, this process works less effectively.

Estimates of the number of epileptic persons in the United States range from 1,000 to 1,500,000. It is difficult to arrive at an accurate figure because of inadequate reporting procedures and the tendency of some parents to conceal the fact that their child has this disorder. It is a fact that possibly one in every 200 persons in this country suffer some type epileptic seizure. The peak age for the development of seizures is during the first two years of age, thus placing it as a developmental disability.

Autism

Autism is the most baffling and least understood of the developmental disabilities. It is characterized by bizarre behavior and violent emotional outburst; and the autistic child is said to be out of contact with his environment. An autistic child is quite different

from the so-called normal child during his first two years.

T. C. Lovass and C. D. Newsom in their Handbook of Behavior Modification and Behavior Therapy describe six (6) common characteristics of autistic children.

1. Apparent Sensory Deficit - The child appears to be oblivious to stimulation.

2. Severe Affect Isolation - Attempts to love and cuddle and show affection to the child; encounters a profound lack of interest on the child's part.

3. Self-Stimulation - Repetitive stereotyped acts, such as rocking their bodies, twirling around, flapping their hands, humming are common. The child might spend entire days gazing at cupped hands, staring at lights, and spinning objects.

4. Tantrums and Self-Mutilating Behavior - The child will bite himself, beat his head against the wall, beat his face with his fists. Sometimes, the child's behavior will be directed against his parents by biting, scratching, and kicking. The parents are often at a loss to cope with the child's behavior.

5. Echolaliac and Psychotic Speech - Most of these children are mute; they do not speak. They may hum or utter simple sounds. The speech of those who do speak echo other people's attempts to speak at them. At times, the echolalia is not immediate but will be delayed; the child will repeat statements he has heard that morning or on the preceding day.

6. Behavior Deficiencies - At the age of five or ten, he will usually show the behavior repertoire of a one-year old child. He/she will have few, if any, self-help skills; will need to be fed and dressed by others. He/she may not play with toys, but put them in his/her mouth.

The preceding six (6) characteristics, as outlined by Lovass and Newsom are descriptive of a profoundly disturbed child.

There are no exact figures as to the incidence of autism, as many children are often not diagnosed as autistic but are often classified as purely psychotic. One estimate is that there are approximately 300,000 autistic children in the United States.

There is no clear theory or concept that fully explains the causative factor for autism. The suggested causes evolve around physiological factors and psychological factors. Many autistic children show signs of neurochemical imbalance, and genetics appear to play a part. However, no one has been able to say with certainty whether the physiological abnormality actually causes the behavior problem or is just associated with it. Research, in terms of relationships between parental child-bearing practices and behavior problems, has been unavailing. It can be stated that autism is baffling and little understood.

Blindness

The blind child is included in the designation developmentally disabled. These children have vision that is of no functional value; loss of vision is so great as to constitute a serious problem with respect to acquiring an education and later economic self-sufficiency. Education is a primary concern for children; therefore, a blind child is forced to utilize methods not commonly used by the majority of children in the school system.

There is an inconsistency of numbers of children who are classified as blind or visually handicapped. The visually handicapped child includes children as follows:

1. Children having visual acuity between 20/70

and 20/200 in the better eye, or who cannot read print smaller than 18 point.

2. Children who have three or more diopters of progressive myopia, especially where there are indications of a pathological condition.

3. Children with visual acuity between 20/50 and 20/220 having congenital cataracts, secondary cataracts, congenital malformations of fundus lesions, corneal opacities, and inactive keratitis.

4. Any child who, in the opinion of an opthalmologist would benefit by placement of a sight-conservation program.

The number of particularly sighted and blind is placed at 45,000.

The major causes of blindness are: heredity, disease, and accidental injury. Causes of blindness related to heredity are: cataract, retinitis pigmentosa, and atrophy of the optic nerve. Infectious diseases are another important cause, such as scarlet fever, syphilis, measles, meningitis, mumps, opthalmalia neonaturum, tuberculosis, and septicemia. It is estimated that about 1,000 children are losing their sight of at least one eye each year through accidents - usually during unsupervised play.

Auditory Disabled

Children who are deaf or hard of hearing have a serious handicap to learning and living. There is no sharp dividing line between the deaf and the hard of hearing. Complete agreement on the classification of the two has never been established. We use as a guide Hard of Hearing; those in whom the sense of hearing, although defective, is functional with or without a hearing aid; who have usuable hearing, and who, in spite of their handicap, did learn language in an unconscious, casual way like the normal-learning child. Deaf - Those in

whom the sense of hearing is nonfunctional, dating from before the age at which the comprehension of speech is normally acquired; who have no usable hearing, and who have never learned language incidentally in the ordinary way - in the way normal hearing children pick it up from their environment - casually, unconsciously.

The number of children with some measurable degree of hearing loss is not known. Definitions of hearing impairment are not uniform; and survey methods have not been standardized. Estimates indicate that many children 5-17 years of age in the United States, approximately 1,700,000 need professional attention and follow-up for hearing problems; and anywhere from 510,000 to 1,000,000 need special medical and educational help, including 34,000 classified as deaf.

The major causes of deafness are: heredity, prenatal conditions, brain disease, and infectious and contagious diseases of childhood.

Additional categories for developmentally disabled children under the new Developmentally Disabled Public Law 95-602 include:

1. Chronic mental illness
2. Multiple amputees
3. Stroke in young adults
4. Spinal cord injury
5. Juvenile arthritis
6. Multiple sclerosis
7. Hemophilia
8. Spina-bifida
9. Childhood diabetes

COURSES

This sequence of two (2) courses is designed to serve the needs of students in human service from the disciplines of social work, psychology, education, physical education, and therapeutic recreation. The courses will be team taught, and include inputs from the aforementioned

disciplines. The primary thrust of the courses are to assist the student in understanding the scope of developmental disabilities, and to establish a basis for collaborative efforts between and among health professionals.

Each course will have a course coordinator, who is responsible for implementing and coordinating the team of faculty.

1. Normal Human Growth and Development — 5 Quarter Hours

The amelioration of deficits manifested by developmental disabilities is based on a sound understanding of normal growth and develoment and the needs of the normal child. The conceptual base of this course is the fact that growth involves physical, social, psychological and learning. The course as a consequence will be divided into five components: physical, social, psychological, learning, and a fifth integrating component.

Prerequisite -- A similar or equivalent course from student's discipline.

2. Nature and Needs of the Developmentally Disabled Child — 5 Quarter Hours

This course will focus on an overview of the developmentally disabled child. The psychosocial and environmental components which are interrelated in understanding developmental disabilities as a medical and social status. Definitions, classifications, etiology, and epidemiological, factors will be considered. Legal, economic, bioethical, educational issues will be surveyed. Service delivery systems and planning implementations will be introduced.

Prerequisite -- Course 1

Field Based Courses

A certificate of proficiency is awarded based on the concept that field based practical experiences will account for a major portion of the curriculum. A student will be supervised and graded by qualified professional staff of the affiliated site. Specific behavioral objectives will be spelled out for each level of practicum field experiences. A seminar session will be held bi-monthly, chaired by the Developmentally Disabilities Committee for students to discuss their observations, learning experiences, and sharing of knowledge with their colleagues from the other disciplines.

3. Seminar and Field Experience with the Developmentally Disabled I — 5 Quarter Hours

This will be an introductory field experience, with the specific objective of sensitizing the student to the developmentally disabled population. Students will be assigned to a staff member, preferably from the student's own discipline who will have adjunct status at Alabama State. Student will be required to interface with the developmentally disabled. Specific behavioral objectives will be spelled out to the students. The grade will reflect the student's ability to meet these objectives.

4. Advanced Seminar and Field Experience with the Developmentally Disabled II — 10 Quarter Hours

This course will involve an opportunity to work intensely with the student's clinical and educational discipline in programming for the developmentally disabled. This course is designed so that the

student will have practical field experience under the supervision of specialist in their disciplines in applying specific rehabilitative and habilitation strategies. The major thrust of the course is to provide a broad experiential base for students to have entry-level skills to permit him/her to become part of an interdisciplinary or transdisciplinary team working with developmentally disabled individuals.

5. Selected Topics in Developmental Disabilities 2 Quarter Hours

The evaluation of the developmentally disabled, goal setting, program planning and selection of intervention techniques.

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